19 Hospital

The Alabama Medicaid Program provides inpatient and outpatient hospital care. The policy provisions for hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* chapter 7.

19.1 Enrollment

EDS enrolls hospitals and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hospital is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospital-related claims.

NOTE:

All eight characters are required when filing a claim.

Hospitals are assigned a provider type of 05 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care (PEC) hospital (WC)
- General hospital (W6)
- Inpatient psychiatric hospital under 21 (W3)
- Inpatient psychiatric hospital over 65 (W2)
- Lithotripsy (L2)
- Mammography (M7)
- Organ transplants (W8)

Enrollment Policy for Hospital Providers

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the Hospital Request for Certification in the Medicare/Medicaid Program (CMS-1514) or its successor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification* Chapter 420-5-7.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to EDS Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

Enrollment Policy for Lithotripsy

The facility must submit an application to EDS Provider Enrollment along with documentation that the lithotripsy machine is FDA approved.

19.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral.

This section includes the following:

Section	*Title*	*Topics Covered*
19.2.1	Inpatient Benefits	• Routine Benefits • Extended Hospital Days for Delivery • Other Extended Benefits • Newborn Inpatient Benefits • Bed and Board and Semi-private Accommodations • Nursing and Other Services • Drugs and Biologicals • Supplies, Appliances, and Equipment • Hemodialysis • Organ Transplants • Blood • Sterilization and Hysterectomy • Abortions • Dental Services • Inpatient Noncovered Services • Payment of Inpatient Hospital Services
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC Provider Number • Admitting a Recipient to a PEC • Reimbursement for PEC Services
19.2.3	Swing Beds	• General Information • Level of Care for Swing Beds • Benefit Limitations for Swing Beds • Admission and Periodic Review
19.2.4	Billing Eligible Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	• Outpatient Surgical Services • Injectable Drugs and Administration • Emergency Hospital Services • Outpatient Hemodialysis • Outpatient Hyperbaric Oxygen Therapy • Obstetrical Ultrasounds • Inpatient Admission after Outpatient Hospital Services • Outpatient Observation • Outpatient Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services
19.2.6	Extracorporeal Shock Wave Lithotripsy (ESWL)	Describes program benefits and limitations for lithotripsy-related services
19.2.7	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.8	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

19.2.1 Inpatient Benefits

This section describes benefits and policy provisions for the following:

Routine Benefits

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

Inpatient benefits for Medicaid recipients are limited to 16 days per calendar year. The number of days of care charged to a recipient for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Extended Hospital Days for Delivery

Medicaid authorizes additional inpatient days for delivery for recipients who have exhausted their initial 16 covered days.

When medically necessary, additional days may be approved for deliveries, from onset of active labor to discharge. The number of extended days must meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria in order to be approved. Inpatient days prior to the onset of active labor will not be approved for extended benefits.

All hospitals should contact Quality Assurance (QA) personnel at (334) 242-5187 for authorization of these deliveries. Requests for authorization should not be made prior to delivery. QA personnel issue a ten-digit authorization number for the approved stays.

Claims for extended benefit days should be filed separately from all other inpatient stays.

Other Extended Benefits

Medically necessary inpatient days are unlimited for recipients under the age of one in all hospitals.

Medically necessary inpatient days are unlimited for children under the age of six if the services are provided by a hospital that has been designated by Medicaid as a disproportionate share hospital.

Newborn Inpatient Benefits

Newborns delivered in the hospital are covered by an eligible mother's claim for up to ten days of well-baby nursery care if the mother is in the hospital and is otherwise entitled to Medicaid coverage.

For recipients living in a maternity care district, no additional newborn nursery care may be billed during the time that has been covered by the global fee (two days for vaginal and four days for C-section deliveries).

For routine hospital delivery of newborns, use revenue codes 170 (Nursery) and 171 (Nursery/Newborn). These revenue codes are reflected on the mother's claims in conjunction with her inpatient stay. The hospital per diem rate includes charges for the mother and newborn. Newborn "well baby" care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or conditions and whose mothers have been discharged or are not otherwise eligible for Medicaid, are not separately billable.

Criteria for Revenue Codes 170/171 - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

Infants delivered outside the hospital, those remaining after the mother is discharged, and those admitted to accommodations other than well-baby nursery must be eligible for benefits in their own right, and a claim for services must be filed under the infant's number. Please note the following examples:

- If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's recipient number even if the mother is still a patient.
- A claim for three days filed under the mother's name and recipient number receiving six nursery days, will be returned to the hospital with instructions to bill the last three days under the baby's name and recipient number, who must be eligible in his own right.

NOTE:

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Unless the newborn infant needs medically necessary, specialized care as defined below, no additional billings for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

Criteria for Revenue Codes 172/173 - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc;
2. Any nutritional disturbances, intestinal problems or known necrotizing entercolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

Criteria for Revenue Code 174 – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;
5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;
7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.;
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

Criteria for Revenue Code 179 – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;
8. IV therapy for unstable conditions or known infection;
9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short term basis pending transfer to a Level III nursery;

10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.

These services should be billed on a separate UB-92 claim form under the infant's name and recipient number. The claim must indicate the ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care. The coding of neonatal intensive care claims will be monitored through post-payment review.

Bed and Board in Semi-Private Accommodations

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

Medically Necessary Private Rooms

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

For the private room to be covered by Medicaid, the following conditions must be met:

- The physician must certify the specific medical condition requiring the need for a private room within 48 hours of admission.
- The physician's written order must appear in the hospital records.

- When the physician certifies the need for continued hospitalization, the private room must also be re-certified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.
- When medical necessity for a private room ceases, the patient should be placed in the semi-private accommodation.

Nursing and Other Services

Medicaid covers nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

Drugs and Biologicals

Medicaid covers drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.

A patient may, on discharge from the hospital, take home remaining drugs that were supplied by prescription or doctor's order, if continued administration is necessary, since they have already been charged to his account by the hospital.

Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid-approved pharmacy. Take-home drugs and medical supplies are not covered by Medicaid as inpatient hospital services.

Supplies, Appliances, and Equipment

Medicaid covers supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of the Medicaid recipient during his inpatient stay in the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, that is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Medicaid as an inpatient hospital service.

Colostomy bags are provided for inpatients only for use while they are hospital patients. Hospitals cannot supply colostomy bags using Medicaid funds for home or nursing facility use.

Hemodialysis

Medicaid provides hemodialysis for chronic renal cases when the patient is not authorized this care under Medicare.

Organ Transplants

Medicaid-covered organ transplants require prior approval, which will be coordinated by the prime contractor. Medicaid's approved prime contractor is responsible for the coordination and reimbursement of all Medicaid-reimbursed organ transplants with the exception of cornea transplants. The Medicaid

Professional Services staff has final approval. Contact the Medicaid Clinic Services Unit at (334) 242-5580 for contractor information.

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Pancreas
- Pancreas/Kidney

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

Blood

Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Sterilization and Hysterectomy

Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in Appendix C, Family Planning.

Any Medicaid service that relates to sterilization or hysterectomy must have documentation on file with Medicaid that shows consent or an acknowledgement of receipt of hysterectomy and sterilization information. This documentation must be submitted by the attending physician and is required to be on file at EDS. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Appendix C, Family Planning, for further details.

NOTE:

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

Abortions

Payment for abortions under Medicaid is subject to the conditions in the chapter pertaining to Physicians. Refer to Chapter 28, Physician, for further details.

Dental Services

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are covered for those recipients eligible for treatment under the EPSDT Program. See Chapter 13, Dentist, for details.

NOTE:

All inpatient hospital claims for dental services require prior authorization with the exception of children aged five and under.

Inpatient Noncovered Services

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.
- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.

- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.
- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric Inpatient Care criteria as defined in the *Alabama Medicaid Agency Administrative Code,* Chapter 44.

Refer to Sections 19.5.2, Procedure Codes and Modifiers, for noncovered inpatient revenue codes.

Payment for Inpatient Hospital Services

Payment for all inpatient hospital services will be from approved per diem rates established by Medicaid or the Partnership Hospital Program (PHP). The PHP is the payer for all in-state hospital acute care days with the exception of recipients with Medicare Part A coverage, Maternity Care, and DYS-CHIP-eligible recipients.

19.2.2 Post Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient
- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

PEC Provider Number

In order to receive reimbursement for PEC, the hospital must enroll with EDS to receive a provider number. The provider number allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a 'PEC' provider number (the number uses the 'PECXXXXH' format).**

Determining the Availability of Nursing Facility Beds

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis

- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Routine medical treatment for a comatose patient

Admission and Periodic Review for PECs

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant's attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

Reimbursement for PEC Services

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

These services are not subject to the inpatient hospital benefit limitations. At this level of care, PEC days are unlimited if a nursing facility bed is not located.

All PEC services must be billed using the PEC provider number with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital provider number (HOSXXXXH).
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy provider number (100XXXXXX).
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

19.2.3 Swing Beds

General Information

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver
- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

Level of Care for Swing Beds

To receive swing bed services, recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.

A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.

Swing bed admissions not covered by Medicare because they do not meet medical criteria are also considered noncovered by Medicaid. These services cannot be reimbursed as a straight Medicaid service.

Benefit Limitations for Swing Beds

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and meets all other eligibility criteria, including financial criteria.

Admission and Periodic Review for Swing Beds

The Medicaid Long Term Care Admissions/Records (LTC ADMS/Records) Unit performs a pre-admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid certifies the level of care required by the patient at the time of admission using the XIX-LTC-4 form. A control number is provided for each patient that is admitted.

The Medicaid staff physician(s) will review applications not initially approved by LTC ADMS/Records.

Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions.

For recipients who receive retroactive Medicaid eligibility while using swing bed services, the hospital must furnish a form MED-54 to Medicaid. Attach all doctors' orders, progress and nurses' notes for the time in question.

LTC ADMS/Records issues medical approvals if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-13 for SNF care.

The admission application packet must be sent to LTC ADMS/Records within 30 days from the date Medicaid coverage is sought and most contain a fully completed Medicaid status notification (form XIX-LTC-4), including documentation certified by the applicant’s attending physician to support the need for the nursing home care.

Once the LTC-4 is reviewed and approved, a prior control number is issued and entered into the Long Term Care Record file.

An LTC-2 form notifies the facility that the patient is medically eligible if the financial eligibility of the patient has been established and entered on the file. If financial eligibility has not been established and noted in the file, an XIX-LTC-2A is sent to the facility advising that medical eligibility is established but financial eligibility is not. If an LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by applying at the District Office.

Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Re-certification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for re-certification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

19.2.4 Billing Eligible Medicaid Recipients

Providers may bill eligible recipients for noncovered services, for example, excessive days beyond benefit limitations, private room accommodation charges incurred due to patient's request, or personal comfort items.

The provider is responsible for informing the recipient of noncovered services. Medicaid recipients in hospitals may be billed for inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient's admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

In the event that the Alabama Medicaid Agency's retrospective review determines that the admission did not meet the Inpatient Care criteria, Medicaid recipients may not be billed for inpatient stays that were initially approved by the hospital's utilization review committee.

Medicaid recipients may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

19.2.5 Outpatient Hospital Services

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are limited to 3 per calendar year unless certified as an emergency.

Outpatient Surgical Services

Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries (within the range of 10000-69XXX) listed in Appendix I, ASC Procedures List, are covered on an outpatient basis. Surgeries listed on the surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.state.al.us.

Patients who remain overnight after outpatient surgery will be considered outpatients UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

NOTE:

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74.

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Outpatient visits for surgical procedures do not count against the recipient's outpatient visit limit. Surgery procedure codes are billed with units of one.

Surgical procedures that are routinely performed in a physician's office and are not listed on the surgical procedures list may be considered for prior approval to be performed in the outpatient setting if medically necessary and if Medicaid approves the procedure.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- All nursing and technician services
- Diagnostic, therapeutic and pathology services
- Pre-op and post-op lab and x-ray services
- Materials for anesthesia
- Drugs and biologicals
- Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: www.medicaid.state.al.us and click on the link for "Outpatient Fee Schedule", or continue to use the AVRS line at EDS (1-800-727-7848) to verify coverage.

NOTE:

Procedures not listed in Appendix I or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

Injectable Drugs and Administration

Injectable drugs from the Alabama Medicaid injectable drug list do not count against the yearly outpatient visit limitation. Refer to Appendix H, Injectable Drug Listing.

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an “E” in field 78 on the UB-92 claim form.

UB-92 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-92 claim form with revenue code 450.

Non-certified visits to the emergency room are considered outpatient visits and count against the three outpatient hospital visits allowed per calendar year.

Outpatient Hemodialysis

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

Obstetrical Ultrasounds

Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Medicaid may approve additional ultrasounds if a patient's documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of birth
- Projected date of requested ultrasound
- Date of last ultrasound
- Number of previous ultrasounds
- Anticipated number of ultrasounds
- Benefit of ultrasounds
- EDC
- Gestational age
- Diagnosis

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.

Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.

- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but less than 24 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 - 99284).

Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99284) with units of one.
- Procedure code 99218 should be used to bill the 4th through 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A detailed or comprehensive history
  - A detailed or comprehensive examination
  - Medical decision-making that is straightforward or of low complexity

The problem(s) requiring admission to “observation status” is usually of low severity.

- Procedure code 99219 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history
  - A comprehensive examination
  - Medical decision-making of moderate complexity

  The problem(s) requiring admission to “observation status” is usually of moderate severity.

- Procedure code 99220 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history
  - A comprehensive examination
  - Medical decision-making of high complexity

  The problem(s) requiring admission to “observation status” is of high severity.

Providers should bill the appropriate CPT code based on the severity of the patient’s condition. Providers may bill up to 20 units of each procedure code.

Units are equal to the number of hours. These codes must be billed with a facility fee (99281-99284). The facility fee is billed with units of one and covers the first three hours. The applicable CPT code would then be billed for the 4th up to the 23rd hour.

Ancillary charges (lab work, x-ray, etc.) may be billed with the facility fee and observation charge.

If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care. (99285)

Medical records are reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

Outpatient Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-92 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

<u>Air or Gas Embolism</u>

9580 9991

Limited to five treatments per year. PA required after five treatments.

<u>Acute Carbon Monoxide Poisoning</u>

986

Limited to five treatments per Incidence.

Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

<u>Decompression Illness</u>

9932 9933

Limited to ten treatments per year. Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

<u>Gas Gangrene</u>

0400

Limited to ten treatments per year. PA required after ten treatments.

Crush Injury

92700 92701 92702
92703 92709 92710
92711 92720 92721
9278 9279 92800
92801 92810 92811
92820 92821 9283
9288 9290 9299
99690 99691 99692
99693 99694 99695
99696 99699

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis
73010 - 73019
Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

70710 70711
70715 70719
70712 70714

Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher.

Radiation tissue damage

52689 7854
9092 990

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

Skin grafts and flaps
99652
Limited to 40 treatments per year.
Twenty treatments to prepare graft site and 20 after graft or flap has been replaced.

Progressive necrotizing infection (necrotizing fasciitis)
72886
Limited to 10 treatments per year. PA required after 10 treatments.

Acute traumatic peripheral
Cyanide poisoning
Ischemia
90253 90301 9031
9040 90441
Limited to 15 treatments per year.

Acute peripheral arterial insufficiency
44421 44422 44481
Limited to five treatments per year. PA required after five treatments.

9877 9890
Limited to five treatments per incident. PA required after five treatments.

Actinomycosis
0390 - 0394
0398 - 0399
Limited to 10 treatments per year.
PA required after 10 treatments.

Exclusions
No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer
Chronic peripheral vascular insufficiency
Anaerobic septicemia and infection other than clostridial
Skin burns
Senility
Myocardial Infarction
Cardiogenic Shock
Sickle Cell Crisis
Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
Acute or chronic cerebral vascular insufficiency
Hepatic necrosis
Aerobic Septicemia
Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)
Tetanus
Systemic aerobic infection
Organ transplantation
Organ storage
Pulmonary emphysema
Exceptional blood loss anemia
Multiple sclerosis
Arthritic diseases
Acute cerebral edema

Outpatient Lab and Radiology

Outpatient visits made solely for lab and radiology procedures do not count against a recipient’s outpatient visit limits.

Claims containing only lab and radiology procedures may be span billed for one calendar month.

Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

Outpatient Chemotherapy and Radiation

Visits for these services do not count against the outpatient visit limitations and may be span billed for a calendar month. See Section 19.5.3, Procedure Codes, and Modifiers, for procedure codes to be used for these services. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

Outpatient Physical Therapy

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

If the therapy continues past the 60th day, there must be evidence in the patient's medical record that a physician or non-physician practitioner has seen the patient within 60 days after the therapy began and every 30 days past the 60th day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Physical therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits. Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Physical therapy records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Medical Criteria for Physical Therapy

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

Plan of Treatment

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name
- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after physical therapy is completed
- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

Prior Approval for Outpatient Services

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician.

Payment of Outpatient Hospital Services

Payment for all outpatient hospital services will be from approved rates as established by Medicaid.

Publicly owned hospitals and hospitals that predominately treat children under the age of 18 years may be paid at an enhanced rate. These payments will not exceed combined payments for providing comparable services under comparable circumstances under Medicare.

Extracorporeal Shock Wave Lithotripsy (ESWL)

Extracoporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half time the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

19.2.6 Outpatient and Inpatient Tests

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests provided in inpatient or outpatient hospital facilities that have been ordered by the attending physician or other staff physician.

19.2.7 Crossover Reimbursement

Part A

Medicaid inpatient hospital days run concurrently with Medicare days. Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment. Medicaid will not make such payments if the Medicaid covered days for the calendar year have been exhausted. This benefit limit does not apply for QMB recipients.

Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. Medicaid pays an amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate.

Part B

Medicaid pays the Medicare Part B deductible and coinsurance according to lesser of the following:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier.

Providers complete the appropriate Medicare claim forms and ensure that the recipient's 13-digit Recipient Identification (RID) is on the form, then forward the completed claim to a Medicare carrier for payment.

QMB-only recipients are eligible for crossover services and are not eligible for Medicaid-only services.

Refer to Chapter 5, Filing Claims, for complete instructions on how to complete the claim form.

Providers in other states who render Medicare services to Medicare/Medicaid-eligible recipients and QMB-eligible recipients should file claims first with the Medicare carrier in the state in which the service was performed.

19.3 Prior Authorization and Referral Requirements

Some procedure codes for hospitalizations require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

In the case of out-of-state referrals, prior authorization is required for select surgical procedures.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission.

The copayment amount for an outpatient visit is $3.00 per visit or $3.00 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost - sharing (copayment) amount imposed.

The copayment amount for an ESWL visit is $3.00 per visit.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers).

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-92.

19.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 82 of the UB-92 claim form.

Certified Emergency Outpatient Visits

Non-certified visits to the emergency room are limited to three per year. Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending physician at the time of the visit. An “E” in field 78 indicates that the visit has been properly certified. Certified emergency claims are also exempt from requiring the Patient 1st referral.

Nonpatient Visits

Specimen and blood samples sent to the hospital for lab work are classified as “nonpatient” since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-92 Billing Instructions, for description of Type of Bill values.

Recipients with Medicare Part B (Medical Only)

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274, 300, 310, 320, 331, 340, 350, 400, 420, 430, 440, 460, 480, 540, 610, 636, 700, 730, 740, 770, 920, and 942.

Charges that are covered by Medicaid but not by Medicare should be filed directly to Medicaid for consideration. It is not necessary to indicate Medicare on the claim. Providers are not required to file claims with Medicare if the service is not a Medicare-covered service.

Split Billing for Inpatient Claims

Claims that span more than one calendar year must be split billed.

Claims that span October 1 of any year should be split billed due to PHP year-end.

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

Claims that span an eligibility change must be split billed.

19.5.1 Time Limit for Filing Claims

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year. The fiscal year begins October 1 and ends September 30.

Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for retroactive coverage with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) will be denied by EDS. Hospitals must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1 of the previous fiscal year are considered outdated. Recipients may not be billed.

Medicaid requires all claims for out-of-state inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

19.5.2 Revenue Codes, Procedure Codes, and Modifiers

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Alabama UB-92 Billing Manual published by the Alabama Hospital Association for a complete listing of valid revenue codes and procedure codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The (837) Institutional electronic claim and paper claim have been modified to accept up to four procedure code modifiers.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Noncovered inpatient revenue codes
- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

Noncovered Inpatient Revenue Codes

The following revenue codes are noncovered on a UB-92 claim form for inpatient services. If covered charges for any of the following revenue codes are indicated on the UB-92 claim form, the claim will be denied.

10X	253	374	54X	610	910-911
14X	254	38X	55X	65X	917
18X	256	403	56X	82X	96X
22X	273	49X	57X	83X	97X
23X	277	52X	58X	84X	98X
24X	29X	53X	59X	85X	99X

Outpatient Revenue Codes

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with noncovered revenue and procedure codes will continue to deny. The claims adjudication system will automatically pay the procedure code with the highest reimbursement rate at 100% of the fee on the pricing file and the subsequent procedures at 50% minus TPL and copay.

Emergency Department

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

CPT Code	***Rev Code***	***Description***
99281 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A problem-focused history, • A problem-focused examination, and

CPT Code	*Rev Code*	*Description*
		• Straightforward medical decision making
99282 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of low complexity
99283 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of moderate complexity
99284 (old code Z5300)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A detailed history, • A detailed examination, and • Medical decision making of moderate complexity
99285 (old code Z5301)	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity

Added: 99285
Deleted: ~~99282, and 99283, and 99284.~~

NOTE:

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-92 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

Added: (the first three hours… observation code).

Deleted: ~~It can only~~
Deleted: ~~99282, 99283, and 99284, not with 99285.~~
Deleted: ~~also cannot~~
Added: may not

Deleted: ~~(Each hour is one unit.)~~

Outpatient Observation

Outpatient Observation is medically necessary extended outpatient care provided to a patient who presents to the emergency department and whose condition warrants more than the three hours of care already included in the emergency department procedure codes 99281-99285 This service is covered only when certified by the attending physician at the time of the service.

Outpatient observation is limited to 23 hours (the first three hours included in the ER facility fee plus up to 20 hours of the appropriate observation code).Observation (99218-99220) may be billed only in conjunction with procedure codes 99281-99285. It may not be billed in conjunction with outpatient surgery. If observation spans midnight, the date of admission should also be the date of discharge on the claim form even though the patient was actually discharged the following day.

Revenue Code	*Procedure Code*	*Description*
76X	99218	Each hour, 4th hour through 23rd hour (maximum units 20), low severity
76X	99219	Each hour, 4th hour through 23rd hour (maximum units 20), moderate severity
76X	99220	Each hour, 4th hour through 23rd hour (maximum units 20), high severity

Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H, Injectable Drug List, of this manual.

Esophagus

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

Laboratory Services

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

NOTE:

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-92 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

Revenue Code	*Procedure Code*	*Description*
39X	36430	Transfusion, blood or blood components

Respiratory Services

Revenue Code	*Procedure Code*	*Description*
412	94010	Spirometry, including graphic record, vital capacity, expiatory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume

Revenue Code	*Procedure Code*	*Description*
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

Physical Therapy and Occupational Therapy

PT is covered for children and adults when provided in an outpatient setting. An EPSDT referral is NOT required for PT services provided in a hospital. OT is covered ONLY for EPSDT-referred recipients or for QMB recipients. Procedure codes listed below in **BOLD** print may be billed by PT or OT providers. Procedure codes marked with * must be billed in conjunction with therapeutic codes (97110-97542) Use revenue codes 421 and 42X for PT claims and revenue code 430 for OT claims.

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10
97001 97001-22	Physical therapy evaluation Physical therapy evaluation-Motorized Wheelchair Assessment		1 1	1 1
97002	Physical therapy re-evaluation		1	
97003 (OT only)	Occupational Therapy evaluation		1	1
97004 (OT only)	Occupational Therapy re-evaluation		1	1
97012*	Traction, mechanical*	1	1	12

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopneumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	
97116	Gait training (includes stair climbing)		1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97504	Orthotics fitting & training, upper and/or lower extremities, each 15 minutes	3	4	16
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	3	4	16
97530 (OT only)	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3	4	96

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	3~~-4~~	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3~~-4~~	4	36
97535 (OT only)	Self-care/home management, each 15 minutes		4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds		1	104
97598	Removal of devitalized tissue from wounds		1	104
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12
97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes	3	4	12

Added: 97597 Removal of devitalized tissue from wounds

Added: 97598 Removal of devitalized tissue from wounds, 1, 104

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.

Orthotics

NOTE:

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals are limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: www.medicaid.state.al.us.

Speech Therapy

NOTE:

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 440 when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597

ESWL

Revenue Code	*Procedure Code*	*Description*
790	50590	Lithotripsy, Extracorporeal shock wave

19.5.3 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

19.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

19.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

19.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N